Drug	Code	Criteria
~~**Abilify**®~~ ~~*(aripiprazole)*~~	~~015~~	~~All of the following must apply:~~ ~~a) There must be an appropriate DSM IV diagnosis; and~~ ~~b) Patient is 6 years of age or older.~~
Accutane® *(isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent**: a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.
Aggrenox® *(aspirin/dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Aloxi® **Injection** (*palonosetron)*	129	Administered as a single dose in conjunction with cancer chemotherapy treatment

Drug	Code	Criteria
Altace® *(ramipril)*	020	Patients with a history of cardiovascular disease.
Ambien® *(zolpidem tartrate)*	006	Treatment of insomnia. Drug therapy is limited to 10 units in 30 days.
Ambien CR® *(zolpidem tartrate)*		See criteria for Ambien®.
Amitiza® *(lubiprostone)*	007	Treatment of chronic constipation. Must have tried and failed a less costly alternative.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atacand® *(candesartan cilexetil)* **Atacand HCT®** *(candesartan cilexetil/HCTZ)* **Avalide®** *(irbesartan/HCTZ)* **Avapro®** *(irbesartan)* **Benicar®** *(olmesartan medoxomil)* **Cozaar®** *(losartan potassium)* **Diovan®** *(valsartan)* **Diovan HCT®** *(valsartan/HCTZ)* **Hyzaar®** *(losartan potassium/HCTZ)* **Micardis®** *(telmisartan)* **Micardis HCT®** *(telmisartan/HCTZ)* **Teveten®** *(eprosartan mesylate)* **Teveten HCT®** *(eprosartan mesylate/HCTZ)*		
Anzemet® *(dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Arava® *(leflunomide)*	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.
Avinza® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Calcium w/Vitamin D Tablets	126	Confirmed diagnosis of osteoporosis, osteopenia, or osteomalacia.
Campral® *(acamprosate sodium)*	041	Diagnosis of alcohol dependency. Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. Treatment is limited to 12 months. The patient must also meet all of the following criteria: a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment; b) Must not be a poly-substance abuser; and c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min). **Note:** A Campral authorization form [DSHS 13-749] must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.
Celebrex®	062	All of the following must apply a) An absence of a history of ulcer of gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.
~~**Clozapine: Clozaril®**~~	~~018~~	~~All of the following must apply:~~ ~~a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and~~ ~~b) Patient is 17 years of age or older; and~~ ~~c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.~~
Copegus® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Coreg® *(carvedilol)*	057	Diagnosis of congestive heart failure.

Drug	Code	Criteria
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
~~**Fazaclo**®~~ ~~*(clozapine)*~~	~~012~~	~~All of the following must apply:~~ ~~a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and~~ ~~b) Patient is 18 years of age or older; and~~ ~~c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above; and~~ ~~d) Must have tried and failed generic clozapine.~~
Gabitril® *(tiagabine HCl)*	036	Treatment of seizures.
~~**Geodon**®~~ ~~*(ziprasidone HCl)*~~	~~046~~	~~All of the following must apply:~~ ~~a) There must be an appropriate DSM IV diagnosis; and~~ ~~b) Patient is 6 years of age or older.~~

Drug	Code	Criteria
Geodon® IM Injection *(ziprasidone HCl)*	058	All of the following must apply: • Diagnosis of acute agitation associated with a psychotic disorder, including bipolar disorder; • Patient is 18 to 65 years of age; and • Maximum dose of 40 mg per day and no more than 3 consecutive days of treatment.
Geodon® IM Injection *(ziprasidone mesylate)*	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.		
Glycolax Powder® *(polyethylene glycol)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Humira® *(adalimumab)*	026	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every 2 weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every 2 weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
Infergen® *(interferon alphcon-1)*	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.

Drug	Code	Criteria
Intron A® *(interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Keppra™ *(levetiracetam)*		See criteria for Gabitril®
Kineret Injection® *(anakinra)*	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® *(granisetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.

Drug	Code	Criteria
Lamisil® *(terbinafine HCl)*		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions: 042 Diabetic foot; 043 History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy; 051 Peripheral vascular disease; or 052 Patient is immunocompromised.
Levorphanol	040	Diagnosis of cancer-related pain.
Lotrel® *(amlodipine-besylate/ benazepril)e*	038	Treatment of hypertension as a second-line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Lunesta™ *(eszopiclone)*		See criteria for Ambien.®
Lyrica® (*pregabalin*)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
Miralax® *(polyethylene glycol)*		See criteria for Glycolax Powder®
Nasonex® (*mometasone furoate*)	015	Patient is 2 to 6 years of age.
Naltrexone		See criteria for ReVia®.
Neurontin® *(gabapentin)*	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuopathy.

Drug	Code	Criteria
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.

Ansaid® *(flurbiprofen)*
Arthrotec® *(diclofenac/misoprostol)*
Bextra® *(valdecoxib)*
Cataflam® *(diclofenac)*
Clinoril® *(sulindac)*
Daypro® *(oxaprozin)*
Feldene® *(piroxicam)*
Ibuprofen
Indomethacin
Lodine®, Lodine XL® *(etodolac)*
Meclofenamate
Mobic® *(meloxicam)*
Nalfon® *(fenoprofen)*
Naprelan®, Naprosyn® *(naproxen)*
Orudis®, Oruvail® (k*etoprofen*)
Ponstel® *(mefenamic acid)*
Relafen® *(nabumetone)*
Tolectin® *(tolmetin)*
Toradol® *(ketorolac)*
Vicoprofen® *(ibuprofen/hydrocodone)*
Voltaren® *(diclofenac)*

Drug	Code	Criteria
Oxandrin® *(oxandrolone)*		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia; b) Nephrosis; c) Carcinoma of the breast; d) Carcinoma of the prostate; and e) Pregnancy.
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
OxyContin® *(oxycodone HCI)*	040	Diagnosis of cancer-related pain.
Parcopa® *(carbidopa/levodopa)*	049	Diagnosis of Parkinson's disease and one of the following: a) Must have tried and failed generic carbidopa/levodopa; or b) Be unable to swallow solid oral dosage forms.
PEG-Intron® *(peginterferon alpha 2b)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Pegasys® *(peginterferon alpha-2a)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Plavix® *(clopidogrel bisulfate)*	116	When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.
	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.

Drug	Code	Criteria
Pravachol® *(pravastatin sodium)*	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Prevacid® **Solutab** *(lansoprazole)*	050	Inability to swallow oral tablets or capsules.
Pulmozyme® *(dornase alpha)*	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
Raptiva® *(efalizumab)*	027	Treatment of plaque psoriasis when prescribed by a dermatologist for patients 18 years or older. Weekly dose is not to exceed 200mg subcutaneously.
Rebetol® *(ribavirin)*		See criteria for Copegus®.
Rebetron® *(ribaviron /interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Remicade Injection® *(infliximab)*	023	Treatment of Crohn's disease or ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum dose is 10mg/kg given every 4 weeks.
Rena-Vite® **Rena-Vite RX**® *(folic acid/vit B comp W-C)*	096	Treatment of patients with renal disease.
ReVia® *(naltrexone HCl)*	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following:

Drug	Code	Criteria
		a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
		☞ **Note:** A ReVia® (Naltrexone) Authorization Form [DSHS 13-677] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html
Ribavirin		See criteria for Copegus®.
~~**Risperdal®**~~ ~~*(risperidone)*~~	~~054~~	~~All of the following must apply:~~ ~~a) There must be an appropriate DSM IV diagnosis; and~~ ~~b) Patient is 6 years of age or older.~~
~~**Risperdal M Tabs®**~~ ~~*(risperidone)*~~	~~054~~	~~All of the following must apply:~~ ~~a) There must be an appropriate DSM IV diagnosis; and~~ ~~b) Patient is 6 years of age or older.~~
Risperdal Consta® IM Injection *(risperidone microspheres)*	059	All of the following must apply: a) There is an appropriate DSM IV diagnosis with a psychotic disorder; b) Patient is 18 to 65 years of age; c) Patient has established tolerance to oral risperidone prior to initiating Risperdal Consta®; and d) Total daily dose is not more than 9mg/day (injectable plus oral at an injectable conversion rate of 25 mg every two weeks IM = 2 mg every day oral).
Roferon-A® *(interferon alpha-2a recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age and older.

Drug	Code	Criteria
Rozerem® *(ramelteon)*		See criteria for Ambien®.
~~**Seroquel**®~~ ~~*(quetiapine fumarate)*~~		~~See criteria for Risperdal®.~~
Sonata® *(zaleplon)*		See criteria for Ambien®.
Soriatane® *(acitretin)*	064	Treatment of severe, recalcitrant psoriasis in patients **16** years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an **absence** of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Sporanox® *(itraconazole)*		Must not be used for a patient with cardiac dysfunction such as congestive heart failure.
	047	Treatment of systemic fungal infections and dermatomycoses. Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; **or**
	052	Patient is immunocompromised.

Drug	Code	Criteria
Suboxone® *(buprenorphine-/naloxone)*	019	Before this code is allowed, the patient must meet all of the following criteria. The patient: a) Is **16** years of age or older; b) Has a DSM-IV-TR diagnosis of opioid dependence; c) Is psychiatrically stable or is under the supervision of a mental health specialist; d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics; e) Is not pregnant or nursing; f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and h) Is enrolled in a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. **Limitations:** • No more than 14-day supply may be dispensed at a time; • Urine drug screens for benzodiazepines, amphetamine/ methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. ***The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;*** • Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and • Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization. **Note:** A Buprenorphine-Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html.
Symbyax® *(olanzapine/ fluoxetine HCl)*	048	All of the following must apply: a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is **6** years of age or older.

Drug	Code	Criteria
Talacen® *(pentazocine HCl/ acetaminophen)* **Talwin NX®** *(pentazocine/naloxone)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Toprol XL® *(metoprolol succinate)*	057	Diagnosis of congestive heart failure.
Topamax®/ Topamax® Sprinkle *(topiramate)*	036	Treatment of Seizures.
	045	Migraine prophylaxis.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after 2 days of metronidazole treatment or the patient is intolerant to metronidazole.
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR and XL® *(bupropion HCl)*	014	Treatment of depression.
Xopenex® *(levalbuterol HCl)*	044	All of the following must apply: a) Patient is 4 years of age or older; and b) Diagnosis of asthma, reactive airway disease, or reversible airway obstructive disease; and c) Must have tried and failed racemic generic albuterol; and d) Patient is not intolerant to beta-adrenergic effects such as tremor, increased heart rate, nervousness, insomnia, etc.
Xopenex HFA® *(levalbuterol tartrate)*	044	See criteria for Xopenex.®
Zelnorm® *(tegaserod hydrogen maleate)*	055	Treatment of constipation dominant Irritable Bowel Syndrome (IBS) in ***women*** when the patient has tried and failed at least two less costly alternatives.
	056	Chronic constipation when the patient has tried and failed at least two less costly alternatives.

Drug	Code	Criteria
Zofran® *(ondansetron HCl)*		See criteria for Kytril®.
Zometa® *(zoledronic acid)*	011	Diagnosis of Hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
~~**Zyprexa**® **Zyprexa Zydis**® *(olanzapine)*~~		~~See criteria for Risperdal®.~~
Zyprexa® **IM Injection** *(olanzapine)*	060	All of the following must apply: a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder; b) Before any subsequent doses are given, patient has been evaluated for postural hypotension and no postural hypotension is present; c) Patient is 18 to 65 years of age; and d) Maximum dose of 30 mg in a 24 hour period.
Zyvox Injectable® *(linezolid)*	013	Treatment of vancomycin resistant infection.
Zyvox Oral® *(linezolid)*	013	Treatment of vancomycin resistant infection
	016	Outpatient treatment of methacillin resistant staph aureas (MRSA) infections when IV vancomycin is contraindicated, such as: a) Allergy; or b) Inability to maintain IV access.

Limitation extensions (LE)

What is a Limitation Extension?

A Limitation Extension (LE) is a request to exceed stated limitations or other restrictions on covered services. LE is a form of prior authorization. HRSA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165. Providers must be able to verify that it is medically necessary to provide more units of prescription drugs than allowed in HRSA's billing instructions and Washington Administration Code (WAC).

Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I get LE authorization?

Limitation extensions may be requested by calling HRSA's Drug Utilization and Review at 1-800-848-2842.

Limitation Extensions DO NOT APPLY to noncovered prescription drugs.
See page C.4 for information on Exception to Rule.